CHAPTER 2
ADDENDUM H

DATA REQUIREMENTS - ADJUSTMENT/DENIAL REASON CODES

FIGURE 2-H-1 DENIAL CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure code is inconsistent with the patient's age.
7	The procedure code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type.
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	"Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider."
16	Claim/service lacks information which is needed for adjudication.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete.
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
47	"This (these) diagnosis(es) is (are) not covered, missing, or are invalid."
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50	These are non-covered services because this is not deemed a "medical necessity" by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/ prescribe/order/perform the service billed.
53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case.
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
89	Professional fees removed from charges.
96	Non-covered charge(s).
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
97	Payment is included in the allowance for another service/procedure.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
106	Patient payment option/election not in effect.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
119	Benefit maximum for this time period has been reached.
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
A1	Claim denied charges.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-1 DENIAL CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
B15	Payment adjusted because this procedure/service is not paid separately.
B17	"Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current."
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	"This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty."
B7	This provider was not certified/eligible to be paid for this procedure/ service on this date of service.
B9	Services not covered because the patient is enrolled in a Hospice.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
SAB8	"Claim/service not covered/reduced because alternative services were available, and should have been utilized."
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-2 DENIAL/ADJUSTMENT CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
15	"Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider."
57	"Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply."
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
62	"Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization."
78	Non-Covered days/Room charge adjustment.
108	Payment reduced because rent/purchase guidelines were not met.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
125	Payment adjusted due to a submission/billing error(s).
137	"Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes."
B19	Claim/service adjusted because of the finding of a Review Organization.
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES

ADJUST/DENIAL REASON CODE	DESCRIPTION
1	Deductible amount
2	Coinsurance amount
3	Co-payment amount
36	Balance does not exceed co-payment amount.
37	Balance does not exceed deductible.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
63	Correction to a prior claim.
64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood Deductible.
67	"Lifetime reserve days. (Handled in QTY, QTY01=LA)"
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
70	Cost outlier amount - Adjustment to compensate for additional costs.
72	"Coinsurance day. (Handled in QTY, QTY01=CD)"
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	"Covered days. (Handled in QTY, QTY01=CA)"
79	Cost Report days. (Handled in MIA15)
80	"Outlier days. (Handled in QTY, QTY01=OU)"
81	Discharges.
82	PIP days.
83	Total visits.
84	Capital Adjustment. (Handled in MIA)
85	Interest amount.
87	Transfer amount.
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
88	Adjustment amount represents collection against receivable created in prior overpayment.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
99	Medicare Secondary Payer Adjustment Amount.
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	"Provider promotional discount (e.g., Senior citizen discount)."
104	Managed care withholding.
105	Tax withholding.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
118	Charges reduced for ESRD network support.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	Psychiatric reduction.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	"Incentive adjustment, e.g. preferred product/service."
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	

FIGURE 2-H-3 ADJUSTMENT/REMARK CODES (CONTINUED)

ADJUST/DENIAL REASON CODE	DESCRIPTION
A0	Patient refund amount.
A2	Contractual adjustment.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A7	Presumptive Payment Adjustment
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B16	Payment adjusted because 'New Patient' qualifications were not met.
B2	Covered visits.
B22	This payment is adjusted based on the diagnosis.
B3	Covered charges.
W1	Workers Compensation State Fee Schedule Adjustment
HIPAA Standard Adjustment Reason Codes Release 06/01/2001	